4. PROGRAM REQUIREMENTS

441.401: Introduction

130 CMR 441.000 establishes the requirements for the provision and reimbursement of chiropractor services under MassHealth. All chiropractors participating in MassHealth must comply with the regulations of the Division governing MassHealth, including but not limited to Division regulations set forth in 130 CMR 441.000 and in 130 CMR 450.000.

441.402: Definitions

The following terms used in 130 CMR 441.000 shall have the meanings given in 130 CMR 441.402 unless the context clearly requires a different meaning. The reimbursability of services defined in 130 CMR 441.402 is not determined by these definitions, but by application of regulations elsewhere in 130 CMR 441.000 and in 130 CMR 450.000.

Chiropractic Manipulative Treatment — the correction of misalignments, subluxations, or segmental joint dysfunction of the bony articulations of the vertebral column, the pelvis, and adjacent areas.

Chiropractor — one who is licensed to practice chiropractic manipulation to correct interference with spinal nerves by adjusting the spinal column.

Office Visit — a visit by a MassHealth member to a chiropractor's office for evaluation and management services. These services do not include chiropractic manipulative treatment.

Primary Care Clinician (PCC) — a provider of managed care to MassHealth members. The PCC must meet the requirements of 130 CMR 450.118(B). The PCC must be a MassHealth-participating provider and must sign a PCC provider agreement with the Division.

Subluxation — a segmental joint dysfunction, misalignment, fixation, or abnormal spacing of the vertebrae.

441.403: Eligible Members

(A) (1) MassHealth Members. The Division covers chiropractor services only when provided to eligible MassHealth members, subject to the restrictions and limitations in the Division's regulations. The Division's regulations at 130 CMR 450.105 specifically state, for each coverage type, which services are covered and which members are eligible to receive those services.

(2) Age Limitations. In addition to any other restrictions and limitations set forth in 130 CMR 441.000 and 450.000, the Division covers chiropractor services only when provided to eligible MassHealth members under age 21.

(3) Recipients of the Emergency Aid to the Elderly, Disabled and Children Program. For information on covered services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program, see 130 CMR 450.106.

(B) For information on verifying member eligibility and coverage type, see 130 CMR 450.107.

441.404: Provider Eligibility

The Division only pays chiropractors who are participating in MassHealth on the date of service. Chiropractors must meet the following eligibility requirements.

(A) In-State Providers. To be eligible to participate in MassHealth, an in-state chiropractor must:

(1) be licensed by the Massachusetts Board of Registration of Chiropractors;
(2) be an active MassHealth provider; and
(3) participate in the Medicare program as a chiropractor.

(B) Out-of-State-Providers. To be eligible to participate in MassHealth, an out-of-state chiropractor must:

(1) obtain a MassHealth provider number and maintain active provider status;
(2) participate in his or her own state's medical assistance program;
(3) be currently licensed as a chiropractor in his or her own state, or in a state that does not license chiropractors, be legally authorized to perform the services of a chiropractor in that state; and
(4) participate in the Medicare program as a chiropractor.

441.405: Out-of-State Chiropractor Services

(A) The Division pays out-of-state chiropractors for reimbursable services provided to an eligible MassHealth member when the chiropractor practices in a community of Connecticut, Maine, New Hampshire, New York, Rhode Island, or Vermont that is within 50 miles of the Massachusetts border and he or she provides reimbursable services to a member who resides in a Massachusetts community near the border of the chiropractor's state. The out-of-state chiropractor's office must be more accessible to the member than the office of an in-state chiropractor who participates in MassHealth.

(B) Prior authorization is required from the Division before a chiropractor whose office is located in a community more than 50 miles from the Massachusetts border may provide reimbursable chiropractor services to a member. Prior authorization will not be granted if the Division determines that the chiropractor's office is less accessible to the member than the office of any other chiropractor participating in MassHealth. All requests for prior authorization must be submitted in accordance with the instructions found in Subchapter 5 of the *Chiropractor Manual*. The Division does not pay for reimbursable services provided at a site more than 50 miles from the Massachusetts border unless the chiropractor obtains prior authorization from the Division before the delivery of service. The Division does not grant retroactive requests for prior authorization.

441.406: Reimbursable Services

The Division pays chiropractors for the following services subject to the restrictions and limitations specified in 130 CMR 441.000: chiropractic manipulative treatment, office visits, and radiology services.

441.407: Service Limitations

(A) The Division pays a chiropractor only for medically necessary treatment related to a neuromusculoskeletal condition. Services must be provided in a chiropractor's office and must have a direct therapeutic relation to the patient's condition. Conditions that may be considered to provide therapeutic grounds for chiropractic treatment include functional disabilities of the spine, nerve pains, and documented incidents that produce sprains and strains of the spinal axis.

(B) The Division does not pay for both an office visit and chiropractic manipulative treatment provided to a MassHealth member on the same day.

(C) The Division limits payment for chiropractor services to a total of 20 office visits or chiropractic manipulative treatments, or any combination of office visits and chiropractic manipulative treatments, up to a total of 20, per member per calendar year. (See 130 CMR 441.409 for limits on radiology services.)

441.408: Referral Requirements

(A) Chiropractor services require a written referral from the member's primary-care provider prior to the delivery of services. If the member is enrolled in the PCC Plan, the member's PCC must make the referral. If the member is enrolled in a Division-contracted managed care organization (MCO), the MCO is responsible for paying for chiropractor services (see 130 CMR 450.117(C)) and the chiropractor must follow the referral requirements of the MCO.

(B) The referral must contain a written certification on letterhead from the member's primary-care provider that states the reason for the referral.

(C) Chiropractors who furnish services to members must report the results of these services to the referring primary-care provider or PCC in writing. The chiropractor may report the results of treatment to the referring provider initially by telephone, but he or she must then submit a written report to the referring provider.

(D) When a member's request for a referral to a chiropractor is denied, the referring provider must document in the member's record the reasons for this denial and communicate the reason for the denial to the member if the member requests it.

441.409: Radiology Services

(A) The Division pays for radiology services when the services are needed to confirm the existence of a neuromusculoskeletal condition requiring treatment.

(B) Payment for radiology services is not included in the fees for office visits or chiropractic manipulative treatment and must be claimed separately.

(C) All equipment used in providing radiology services must be inspected and approved by the Massachusetts Department of Public Health.

(D) The Division only pays chiropractors for those radiology services provided in the chiropractor's office and only when the films are developed and read in the chiropractor's office.

(E) All X rays must be labeled with the member's name, date of the exam, and the nature of the exam and must be maintained in the member’s medical record in accordance with 130 CMR 441.412.

441.410: Nonreimbursable Services

The Division does not pay chiropractors for any other services provided or ordered by a chiropractor. Such services include, but are not limited to, the following:

(A) the chiropractic treatment of diseases and pathological disorders other than those related to a neuromusculoskeletal condition (including, but not limited to, rheumatoid arthritis, muscular dystrophy, multiple sclerosis, pneumonia, and emphysema);

(B) chiropractic manipulative treatment, office visits, and radiology services not personally provided by the chiropractor, in accordance with 130 CMR 450.301;

(C) chiropractor services provided in settings other than the chiropractor's office. Such settings include, but are not limited to, inpatient or outpatient hospitals, nursing facilities, rest homes, and the member's home;

(D) laboratory services;

(E) orthotic devices, corrective devices, and orthopedic appliances;

(F) research, or experimental, unproven, or medically unnecessary procedures or treatment;

(G) maintenance therapy, that is, chiropractic manipulative treatment to maintain health or prevent regression when the member is no longer suffering or presenting symptoms;

(H) supportive services such as, but not limited to, nutritional counseling, educational services, and printed materials;

(I) physiotherapy, physical therapy, muscular stimulation, heat packs, or massage; and

(J) vitamins, minerals, food supplements, or other such supplies.

441.411: Payment for Services

To receive payment for medically necessary chiropractor services, the chiropractor must comply with the following conditions.

(A) For members who are not enrolled in the PCC Plan, the chiropractor must obtain and maintain, in the member's medical record, a copy of the primary-care provider's written referral.

(B) For members enrolled in the PCC Plan, the chiropractor must enter the PCC referral number on the claim form. A copy of the PCC's written referral must be maintained in the member's medical record.

441.412: Recordkeeping Requirements

(A) Federal and state regulations require that all MassHealth providers maintain complete written medical records of all patients who are MassHealth members. Medical records must comply with the provisions of 233 CMR 4.04. All records must be kept for a minimum of six years after the date of service. Payment for maintaining the member's medical record is included in the fee for chiropractic services. Each medical record must contain sufficient information to document fully the nature, extent, quality, and necessity of the care furnished to the member for each date of service claimed for payment. If the documentation is not sufficient to justify the service for which payment is claimed by the provider, MassHealth will not pay for the service or, if payment has been made, may consider such payment to be an overpayment subject to recovery in accordance with MassHealth's administrative and billing regulations at 130 CMR 450.000.

(B) The medical records must contain the following:
(1) MassHealth member identification, including name, address, telephone number, date of birth, and the MassHealth member's identification number;
(2) a complete medical history;
(3) examination results, including a description of the chief complaint and diagnosis;
(4) a written referral from the member's primary-care provider or PCC;
(5) copies of X rays, with interpretations;
(6) copies of all prior-authorization requests for out-of-state services;
(7) the date and nature of each visit, including a complete description of services furnished, written and signed by the chiropractor;

(8) when more than one visit is indicated, a treatment plan for future visits written and signed by the chiropractor, which is updated on an ongoing basis to reflect changes in the member's presenting symptoms;
(9) upon completion of treatment, a summary of the treatment and the member's current condition;
(10) recommendations for additional treatment, signed and dated by the chiropractor; and
(11) if the medical record or any component included therein is released for use by another party, the medical record must also contain a release form signed by the member. Release of the medical record to MassHealth for authorized use does not require the member's consent.

441.413: Rates of Payment

(A) The Massachusetts Division of Health Care Finance and Policy determines the maximum allowable fees for chiropractor services. Payment is subject to the conditions, exclusions, and limitations set forth in 130 CMR 441.000. Payment for a service will be the lower of the following:
(1) the provider's usual and customary fee; or
(2) the maximum allowable fee listed in the applicable Division of Health Care Finance and Policy fee schedule and the applicable sections of 130 CMR 450.000.

(B) Maximum allowable fees for chiropractor services include payment for all aspects of service delivery including administrative costs. Providers may not bill separately for services such as, but not limited to, the following:
(1) telephone contacts;
(2) information and referral services; and
(3) recordkeeping.

REGULATORY AUTHORITY

130 CMR 441.000: M.G.L. c 118E, ss. 7 and 12.